APPENDIX E-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 1443 (HFS 1443), PROVIDER INVOICE

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Use original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the form.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, which is the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude the Department's correction of certain billing errors.
Conditionally Required	=	Entries which are required based on entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of audiology services.

COMPLETION		ITEM EXPLANATION AND INSTRUCTIONS
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the Provider Number exactly as it appears on the Provider Information Sheet.
Required	**3.**	**Payee** - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Not Required	4.	Group - Leave blank.
Not Required	5.	Role - Leave blank.
Not Required	6.	Prior Approval - Leave blank.
Optional	**7.**	**Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If the address is not entered, the Department will not attempt corrections.
Conditionally Required	**8.**	**Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office).

Optional	**9.**	**Provider City State Zip** - Enter city, state and zip code of provider.
Required	**10.**	**Referring Practitioner Name** - Enter the name of the otologist, otolaryngologist or primary physician who referred the patient for audiology services.
Required	**11.**	**Recipient Name** - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
Required	**12.**	**Recipient No.** - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Optional	**13.**	**Birthdate** - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card, KidCare Card or Notice of Temporary KidCare Medical Benefits. Use the MMDDYYYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to recipient name or number errors. If the birthdate is not entered, the Department will not attempt corrections.
Not Required	14.	H. Kids - Leave blank
Not Required	15.	Fam Plan - Leave blank
Not Required	16.	St/Ab - Leave blank
Required	**17.**	**Primary Diagnosis Description** - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Required	**18.**	**Primary Diag. Code** - Enter the specific ICD 9-CM code without the decimal for the primary diagnosis described in Item 17.
Required	**19.**	**Taxonomy** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.

Optional	**20.**	**Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. - Leave blank.
Not Required	22.	Secondary Diag. Code - Leave blank
	23.	**Service Sections**: Complete one Service Section for each item or service provided to the patient.
Required		**Procedure Description/Drug Name, Form, and Strength or Size** - Enter the description of the service provided or item dispensed.
Required		**Proc. Code/NDC** - Enter the appropriate CPT, HCPCS or NDC.
Required		**Date of Service** - Enter the date the service was provided. Use MMDDYY format.
Required		**Cat. Serv.** - Enter the appropriate two-digit code for the category of service code. 14 - Audiology Services
Conditionally Required		**Delete** - When an error has been made that cannot be corrected enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required		**Place of Serv.** - Enter the two-digit Place of Service code from the following list: 11 – Office 12 – Home 13 – Assisted Living Facility 14 – Group Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility
Conditionally Required		**Units/Quantity** - Enter the appropriate number of units for the service.
Not Required		Modifying Units - Leave blank

Conditionally Required

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the Chapter 100, General Appendix 9. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in section 25.

Spenddown – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples

When the date of service is the same as the "Spenddown Met" date on the DPA 2432 (Split Billing Transmittal) attach the DPA 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432 shows a recipient liability greater than $0.00 the Service Section should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	The actual recipient liability as shown on DPA Form 2432.
TPL Date	The issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432 shows a recipient liability of $0.00 the Service Section should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	The issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

Conditionally Required

Status - If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown - TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.
02 - TPL Adjudicated - patient not covered - TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 - TPL Adjudicated - services not covered - TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
04 - TPL Adjudicated - spenddown met - TPL status code 04 is to be entered when the patient's Form DPA 2432 shows $0.00 liability.
05 - Patient not covered - TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 - Services not covered - TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 - Third Party Adjudication Pending - TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
10 - Deductible not met - TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount - Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.

Conditionally Required

TPL Date - A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Status Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432, Split Billing Transmittal
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required 24. Optical Materials Only - Leave blank.

Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If an additional third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

Conditionally Required **25.** **Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section number (1 through 6) in which that service is reported.

If a third party made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 25C will be applied to the total of all Service Sections on the Provider Invoice.

Conditionally Required **25A.** **TPL Code** - Enter the appropriate TPL Code referencing the source of payment (Chapter 100, General Appendix 9). If the TPL Codes are not appropriate enter 999 and enter the name of the payment source in section 35.

Conditionally Required **25B.** **Status** - Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.

Conditionally Required **25C** **TPL Amount** - Enter the amount of payment received from the third party resource.

Conditionally Required	**25D.**	**TPL Date** - Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above for correct coding of this field.)
Conditionally Required	**26.**	**Sect. #** - (See 25 above).
Conditionally Required	**26A.**	**TPL Code** - (See 25A above).
Conditionally Required	**26B.**	**Status** - (See 25B above).
Conditionally Required	**26C.**	**TPL Amount** - (See 25C above).
Conditionally Required	**26D.**	**TPL Date** - (See 25D above).
Conditionally Required	**27.**	**Sect. #** - (See 25 above).
Conditionally Required	**27A.**	**TPL Code** - (See 25A above).
Conditionally Required	**27B.**	**Status** - (See 25B above).
Conditionally Required	**27C.**	**TPL Amount** - (See 25C above).
Conditionally Required	**27D.**	**TPL Date** - (See 25D above).

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	**28.**	**Tot Charge** - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
Required	**29.**	**Tot Deductions** - Enter the sum of all payments submitted in the TPL Amount field in Service Sections 1 through 6. If no payment was received, enter zeroes (0 00).
Required	**30.**	**Net Charge** - Enter the difference between Total Charge and Total Deductions.

Required	**31.**	**# Sects** - Enter the total number of Service Sections completed in the top part of the form. This entry must be at least one and no more than six. Do not count any sections which were deleted because of errors.
Not Required	32.	Original DCN - Leave blank.
Not Required	33.	Sect. - Leave blank.
Not Required	34.	Bill type - Leave blank.
Conditionally Required	**35.**	**Uncoded TPL Name** - Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
Required	**36-37**	**Provider Certification, Signature and Date** - After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format.

MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or DPA 2432, Split Billing Transmittal) are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, NIPS Special Invoice Handling Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Forms Requisition

Billing forms may be requested on our Web site at http://www.hfs.illinois.gov/forms/ or by submitting a 1517 or 1517A as explained in Chapter 100, General Appendix 10.

PROVIDER INVOICE

ILLINOIS DEPARTMENT OF PUBLIC AID

USE CAPITAL LETTERS ONLY

PRV

IDPA USE ONLY

1. PROVIDER NAME (FIRST, LAST) | 2. PROVIDER NUMBER | 3. PAYEE | 4. ROLE | 5. EMER | 6. PRIOR APPROVAL

7. PROVIDER STREET | 8. FACILITY & CITY WHERE SERVICE RENDERED

9. PROVIDER CITY | STATE | ZIP | 10. REFERRING PRACTITIONER NAME (FIRST, LAST)

11. RECIPIENT NAME (FIRST, MI, LAST) | 12. RECIPIENT NUMBER | 13. BIRTHDATE | 14. H. KIDS | 15. FAM. PLAN | 16. ST/AB

17. PRIMARY DIAGNOSIS DESCRIPTION | 18. PRIMARY DIAG. CODE

19. TAXONOMY | 20. PROVIDER REFERENCE | 21. REF. PRAC. NO. | 22. SECONDARY DIAG. CODE

23. SERVICE SECTIONS

1 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

2 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

3 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

4 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

5 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

6 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

24. OPTICAL MATERIALS ONLY

24A. RX TYPE | 24B. LENS TYPE | 24C. CORRECTION CHANGE

24D. RIGHT SPHERE | 24E. RIGHT CYLINDER | 24F. RIGHT PRISM

24G. LEFT SPHERE | 24H. LEFT CYLINDER | 24I. LEFT PRISM

25. SECT. # | 25A. TPL CODE | 25B. STATUS | 25C. TPL AMOUNT | 25D. TPL DATE

26. SECT. # | 26A. TPL CODE | 26B. STATUS | 26C. TPL AMOUNT | 26D. TPL DATE

27. SECT. # | 27A. TPL CODE | 27B. STATUS | 27C. TPL AMOUNT | 27D. TPL DATE

28. TOT. CHARGE

29. TOT. DEDUCTIONS

30. NET CHARGES

31. #SECT | 32. ORIGINAL DCN | 33. SECT | 34. BILL TYPE | 35. UNCODED TPL NAME

I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE SIDE AND IS PART OF THIS BILL.

36. PROVIDER SIGNATURE (DO NOT USE RUBBER STAMP) | 37. DATE

DPA 1443 (R-4-04)
IL478-1210

Completion mandatory, III. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center.

Job# 086583 - 3/2004

APPENDIX E-2

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 2210, MEDICAL EQUIPMENT/SUPPLIES INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-coping a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims.

Appendix E-2a is a copy of Form DPA 2210, Medical Equipment/Supplies Invoice. Instructions for completion of the invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies required and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude the Department's correction of certain billing errors.
Conditionally Required	=	Entries which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of audiology services.

COMPLETION STATUS	ITEM
	Document Control Number - leave blank.
Required	1. **Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	2. **Provider Number** - Enter the Provider Number exactly as it appears on the Provider Information Sheet.
Required	3. **Payee** - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

Required

4. **Billing Date** - Enter the date the invoice was prepared. Use MMDDYY format.

Optional

5. **Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is filled in, the same data will appear on Form DPA M-194-1, Remittance Advice, returned to the provider.

Optional

6. **Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.

Optional

7. **Provider City State Zip** - Enter city, state and zip code of provider. See item 6 above.

8. **Service Sections:** Complete one Service Section for each item or service provided to the patient.

Required

Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Required

Recipient Number - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan Card or KidCare Card. Use no punctuation or spaces. Do NOT use the Case Identification Number.

If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the invoice and attach a copy of the Temporary MediPlan Card to the invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.

Conditionally Required

Birthdate - Enter the month, day and year of birth of the patient as shown on the Mediplan Card, Temporary Mediplan Card or KidCare Card. Use the MMDDYY format.

Conditionally Required	**Acc/Inj** - This is a one-digit numeric field. When applicable, enter one of the following Accident/Injury Codes to indicate the probable reason the patient sought treatment. 1 - Employment - The patient's injury is due to work related accident or illness. 2 - Motor Vehicle - The patient's injury was received while operating a motor vehicle or as a passenger in a motor vehicle, or another type of accident involving a motor vehicle. 3 - Athletic - The patient's injury is due to participation in an organized sport or school activity. 4 - Victim - The patient's injury is due to an act of violence (non-accidental). 5 - Other - The patient's injury is the result of an unspecified accident.
Not Required	**Healthy Kids** - Leave blank.
Not Required	**Cr. Child** - Leave blank.
Conditionally Required	**Delete** - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	**Diagnosis Description** - Diagnosis description is required when a hearing aid is dispensed. Enter the diagnosis description for the condition responsible for the need for a hearing aid. (The diagnosis should be provided by the referring specialist or primary physician.)
Conditionally Required	**Prefix -** When the diagnosis code in the ICD-9-CM has an alphabetic prefix of "E" or "V," enter it here.

Required	**Diag. Code** - Enter the ICD-9-CM code for the diagnosis described in "Diagnosis Description" field (item H above). All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line.
Conditionally Required	**Ordering Practitioner Name** - If the only service provided is evaluation for a hearing aid, no entry is required. For all other services or items, enter the name of the otologist or otolaryngologist (or primary physician) who referred the patient to the audiologist.
Conditionally Required	**Ord. Prac. No.** - If the ordering practitioner name is completed, enter the ordering practitioner's state license number, Social Security Number, or AMA number.
Not Required	**Order Number** - Leave blank.
Not Required	**Prior Approval** - Leave blank.
Required	**Cat. Serv.** - Enter the appropriate two-digit code for the category of service provided. The applicable codes which can be billed on this form are: 41 - Medical Equipment (for hearing aids and repairs) 48 - Supplies (for batteries)
Required	**Item -** Enter the appropriate five-digit HCPCS or Department-generated code for the service or item. Refer to Topic E-202 for information on obtaining a list of all covered services and items.
Required	**Pur./Rent** - Enter "1".
Required	**Quantity** - Enter the quantity. When a charge is being submitted for batteries, enter the number of individual batteries, not packages.
Required	**Date of Service** - Enter the date the service was provided. Use the MMDDYY format.

Conditionally Required

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required except as follows.

SPENDDOWN - Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (Split Billing Transmittal). When a Form DPA 2432 is necessary, Form DPA 2212, should be completed as follows:

- Enter 906 in the TPL CODE field.
- Enter a 01 in the TPL STATUS field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability.
- From the Form DPA 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 2212. This amount may be $0.00.
- From the Form DPA 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form DPA 2212.
- The TPL fields must be completed in each Service Section that has the same date of service as the SPLIT BILL day. The Spenddown liability is to be divided and reported in the TPL AMOUNT field of each Service Section that has the same date of service.

Conditionally Required

Status - If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code = 000.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 must be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 must be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 must be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 must be entered when the patient's Form DPA 2432, Split Billing, shows $0.00 liability.

05 - Patient not covered: TPL Status Code 05 must be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 must be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Third Party Estimated Payment: TPL status code 08 must be entered when contact has been made with the third party and payment is forthcoming, but has not yet been received. The provider is responsible for initiating an adjustment if the actual amount of TPL monies received differs from the Estimated Amount reported.

10 - Deductible not met: TPL Status Code 10 must be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount - If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource or the patient. A dollar amount entry is required if TPL Status Code 01 or 08 was entered in the "Status" box.

Conditionally Required

TPL Date - A TPL date is required when any Status code is shown. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432
05	Date of Service
06	Date of Service
07	Date of Submittal to TPL Resource
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Optional

Repeat - In the second though seventh Service Sections, a field titled “Repeat” appears at the beginning of the Service Section. This field may be used, by entry of a capital “X” in the box, to eliminate the need to repeat any data field except the Date of Service and any TPL related fields.

Conditionally Required

9. **Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

ITEMS 10 AND 11 HAVE BEEN DELETED

Conditionally Required

12. **Sec. #** - This field must be completed either when there is additional TPL for a specific Service Section or the TPL is to be applied to all Service Sections on the invoice. If the TPL data is for a specific Service Section, the Service Section number must be entered in this field. If the TPL is to be applied to all Service Sections, an “O” must be entered in this field.

Conditionally Required **13A.** **TPL Code** - Refer to item 8 for the instructions for the TPL code.

Conditionally Required **13B.** **Status** - Refer to item 8 for the instructions for the TPL status.

Conditionally Required **13C.** **TPL Amount** - Refer to item 8 for the instructions for the TPL amount.

Conditionally Required **13D.** **TPL Date** - Refer to item 8 for the instructions for the TPL date.

Required **14.** **# Sects.** - Enter the total number of Service Sections completed correctly in the top part of the invoice. This entry must be at least 1 and no more than 5. Do not count any sections which were deleted because of errors.

The three claim summary fields must be completed on all Medical Equipment/Supplies Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are to be completed in accordance with the following instructions

Required **15.** **Total Charge** - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 5.

Required **16.** **Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

Required **17.** **Net Charge** - Enter the difference between Total Charge and Total Deductions.

Required **18.** **Provider Certification, Signature and Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date must be entered.

MAILING INSTRUCTIONS

The Medical Equipment/Supplies Invoice is a two-part form. The provider must submit the original to the Department as indicated below. The copy of the claim should be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Claims must be mailed to the Department in the pre-addressed mailing envelope, DPA 2247, Medical Equipment/Supplies Invoice Envelope, provided by the Department.

Claims with attachments must be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, Special Approval Envelope, which is provided by the Department.

APPENDIX E-2a
Reduced Facsimile of Form DPA 2210, Medical Equipment/Supplies Invoice

MEDICAL EQUIPMENT / SUPPLIES INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID

IDPA Use only

ELITE PICA b TYPEWRITER ALIGNMENT **USE CAPITAL LETTERS ONLY** ELITE PICA

222

1. Provider Name | 2. Provider Number | 3.Payee | 4. Billing Date | 5. Provider Reference

6. Provider Street | 7. Provider City | State | Zip

Service 8.Sections

Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

1

Repeat | Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

2

Note: Center section of form has been removed to enlarge detail. The actual form has 5 service sections.

Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

5

9. Uncoded TPL Name

14.#Sects | 15.Total Charge

12. Sec.# | 13A.TPL Code | 13B.Status | 13C.TPL Amount | 13D.TPL

16.Total Deductions

17.Net Charge

My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.
"Completion mandatory, IL.Rev.Stat., Ch. 23, P.A.Code, penalty non-payment. Form Approved by the Forms Management Center."

IL 478-1105
DPA 2210 (R) - 3 - 94)

Provider Signature | Date

APPENDIX E-3

PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 2240, EQUIPMENT PRIOR APPROVAL REQUEST

Form DPA 2240, Equipment Prior Approval Request, must be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services requiring prior approval are identified in the handbook.

Appendix E-3a contains a facsimile of Form DPA 2240. The form provides space to request up to three items for the same patient.

INSTRUCTIONS FOR COMPLETION

The form must be typewritten or legibly handprinted. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required. If any required items are left blank, the form will be returned as invalid.
Conditionally Required	=	Entries which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable for services by audiologists; leave blank.

ITEM EXPLANATION AND INSTRUCTIONS

Not Required	**1.**	**Trans Code (Transaction Code)** - Leave blank.
Not Required	**2.**	**Prior Approval Number** - Leave blank.
Not Required	**3.**	**Case Name** - Leave blank. The case name appears on the front of the card in conjunction with the mailing address.

Required	**4.**	**Recipient Name** - Enter the name of the patient for whom the service is requested.
Required	**5.**	**Recipient Number** - Enter the nine-digit recipient number assigned to the patient for whom the service is requested. This number is found to the right of the patient's name on the back of the MediPlan or KidCare Card.
Required	**6.**	**Birthdate** - Enter the patient's birthdate.
Not Required	**7.**	**Inst Set (Institutional Setting)** - Leave blank.
Not Required	**8.**	**Case Identification Number** - Leave blank. This number is found in the primary portion (front) of the card immediately above the case name and mailing address.
Required	**9.**	**Recipient Street Address** - Enter the patient's current street address.
Required	**10.**	**Diagnosis Description** - Enter the written diagnosis which describes the condition primarily responsible for the need for the item being requested.
Required	**11.**	**Recipient City, State, Zip** - Refer to Item 9 above.
Required	**12.**	**Diagnosis Code** - Enter the ICD-9-CM diagnosis code that corresponds to the diagnosis described in item 10 above.
Required	**13.**	**Ordering Provider Name** - Enter the name of the otologist, otolaryngologist or primary care physician recommending the patient receive the specific item/service.
Required	**14.**	**Order. Prov. No.** (**Ordering Provider Name**) - Enter the ordering physician's state medical license number, UPIN, social security number or the provider number assigned by the Department.

Not Required	**15.**	**Facility Name** - Leave blank.
Required	**16.**	**Provider Street** - Enter the ordering physician's street address.
Required	**17.**	**Provider Telephone** - Enter the telephone number of the ordering physician's office.
Not Required	**18.**	**Facility City** - Leave blank.
Required	**19.**	**Provider City, State, Zip** - Enter the city, state, and zip code of the ordering physician.
Required	**20.**	**Supplying Provider Name** - Enter the name of the provider who will render the service.
Required	**21.**	**Supply Prov No (Supplying Provider Number)** - Enter the supplying provider's number exactly as shown on the Provider Information Sheet.
Required	**22.**	**Provider Street** - Enter the supplying provider's street address.
Required	**23.**	**Provider Telephone** - Enter the telephone number of the supplying provider's office.
Required	**24.**	**Provider City, State, Zip** - Enter the city, state, and zip code of the supplying provider. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Not Required	**25.**	**Approving Authority** - Leave blank.
Not Required	**26.**	**Disposition Date** - Leave blank.
Not Required	**27.**	**Approving Authority Signature** - Leave blank.

Not Required	**28.**	**Receipt Date** - Leave blank.
Required	**29.**	**Service Sections** - The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:
Required		**Req. Item No. (Requested Item Number)** - Enter the appropriate five-digit CPT, HCPCS or Department-generated code for the service or item. Refer to Topic E-202 for information on obtaining a list of all covered services and items.
Required		**Req Qty (Requested Quantity)** - Enter the number of items to be dispensed in the period covered by the prior approval.
Required		**Prov Charge (Provider Charge)** - Enter the provider's usual and customary charge.
Required		**Cat. Serv. (Category of Service)** - Enter the appropriate two-digit code of either 41 or 48.
Required		**Description** - Briefly describe the service or item to be provided. If an item has been delivered, enter the date of service. If additional space is needed, provide the information on letterhead paper, identifying the patient by name and Recipient Identification Number.
Not Required		**Disposition Status** - Leave blank.
Not Required		**Aprv Item No. (Approved Item Number)** - Leave blank.
Not Required		**Aprv Qty (Approved Quantity)** - Leave blank.

Not Required		**Unit Amount** - Leave blank.
Required		**Purchase/Rental** - Enter “1".
Not Required		**Total Amount** - Leave blank.
Conditionally Required		**Begin Date** - If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval request is granted, leave this item blank.
Not Required		**End Date** - Leave blank. The approving authority will enter the last day on which the item or service may be provided.
Not Required		**Reason For Denial** - Leave blank.
Conditionally Required	**30.**	**Medical Necessity/Additional Diagnoses** - The provider must enter a statement as to the need for the item(s) or service(s) requested, how the item or service is expected to correct or help the condition, and why the requested treatment plan is better than any other plan commonly used to deal with similar diagnoses or conditions. If additional space is needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.
Required	**31.**	**Supplying Provider Signature** - The form must be signed in ink by the individual who is to provide the item or service.
Required	**32.**	**Request Date** - Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. Attach documentation for hearing aid requests as specified in the handbook. The top, signed copy of the request must be mailed to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124
(Use pre-addressed envelopes, Form DPA 2294, Equipment Supplies Prior Approval Envelope, supplied by the Department.)

A notification of approval or denial of the service(s) will be mailed to the provider.

APPENDIX E-3a
Reduced Facsimile of Form DPA 2240, Equipment Prior Approval Request

EQUIPMENT
PRIOR APPROVAL REQUEST

Illinois Department of Public Aid

Document Control Number

EEE

1.Trans Code | 2.Prior Approval Number | 3.Case Name

4.Recipient Name (First, MI, Last) | 5.Recipient Number | 6.Birthdate | 7.Inst.Set | 8.Case Number

9.Recipient Street | 10.Diagnosis Description

11.Recipient City | State | Zip | 12.Diagnosis Code

13.Ordering Provider Name | 14.Order Prov.No. | 15. Facility Name

16.Provider Street | 17.Provider Telephone ( ) | 18. Facility City

19.Provider City | State | Zip

20.Supplying Provider Name | 21.Supply Prov.No.

22.Provider Street | 23.Provider Telephone ( )

24.Provider City | State | Zip

25.Aprv.Authority | 26.Disp.Date | 27. Approving Authority Signature | 28.Receipt Date

29.SERVICE SECTIONS

1	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial
2	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial
3	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATU	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial

30. Medical Necessity/Additional Diagnoses

This is to certify that the information above is true, accurate and complete.

Completion Mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment.

31. Supplying Provider Signature

32Request Date

DPA 2240 (R-11-91)

IL478-1070

APPENDIX E-3b

Facsimile of
BINAURAL HEARING AID QUESTIONNAIRE

Patient Name_____Recipient ID#_____

In order to make an informed recommendation to approve or deny a binaural hearing aid system, our physician consultants need the following information:

1) Why is it **necessary** this patient have a binaural system?
_____

2) Is the patient's hearing in the poorer ear 25 dB. less than the hearing in the better ear?_____

3) Could "Cros" hearing aids be considered?_____

4) Is the patient going to school, vocational training, or working in a dangerous area where sound from both sides is essential? _____

Please explain:

Without this information being supplied for our review, a request cannot be considered for either approval or denial.

Signed_____
Ordering Physician

Date_____

M-206.26a

APPENDIX E- 4

PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Intermediary or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare intermediary on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine- digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare intermediary automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare intermediary but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,
- the provider's Provider Number in the lower right corner of Field 33, and
- the one-digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name.

If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a

separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare intermediary. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443 or Form DPA 2210 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.

APPENDIX E-5

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. Refer to Topic E-201.4 for instructions. If all the information noted on the sheet is correct, the provider should keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix E-5a. The item or area numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

	FIELD	EXPLANATION
1	**PROVIDER KEY**	This number uniquely identifies the provider and must be used as the provider number when billing charges to the Department.
2	**PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three-digit **COUNTY** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
3	**ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code and corresponding narrative which indicates the provider's classification. **ORGANIZATION TYPE** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which

the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Intent to Terminate
B = Expired License
C = Citation to Discover Assets
D = Delinquent Child Support
F = Fraud Investigations
G = Garnishment
I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested By Provider Participation Unit
T = Tax Levy
X = Tax Suspensions

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/ LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's Social Security or FEIN number.

6 **ELIGIBILITY CATEGORY OF SERVICE**

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

014 = Audiology Services
041 = Medical Equipment/Prosthetic Devices
048 = Medical Supplies

Each entry is followed by the date that the provider was approved to render services for each category listed.

The provider is not to include the "0" in the above code when completing the Category of Service field on billing invoices.

7 **PAYEE INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **PAYEE CODE**, which must be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. To the right of this number is the effective date when payment may be made to each payee on behalf of the provider.

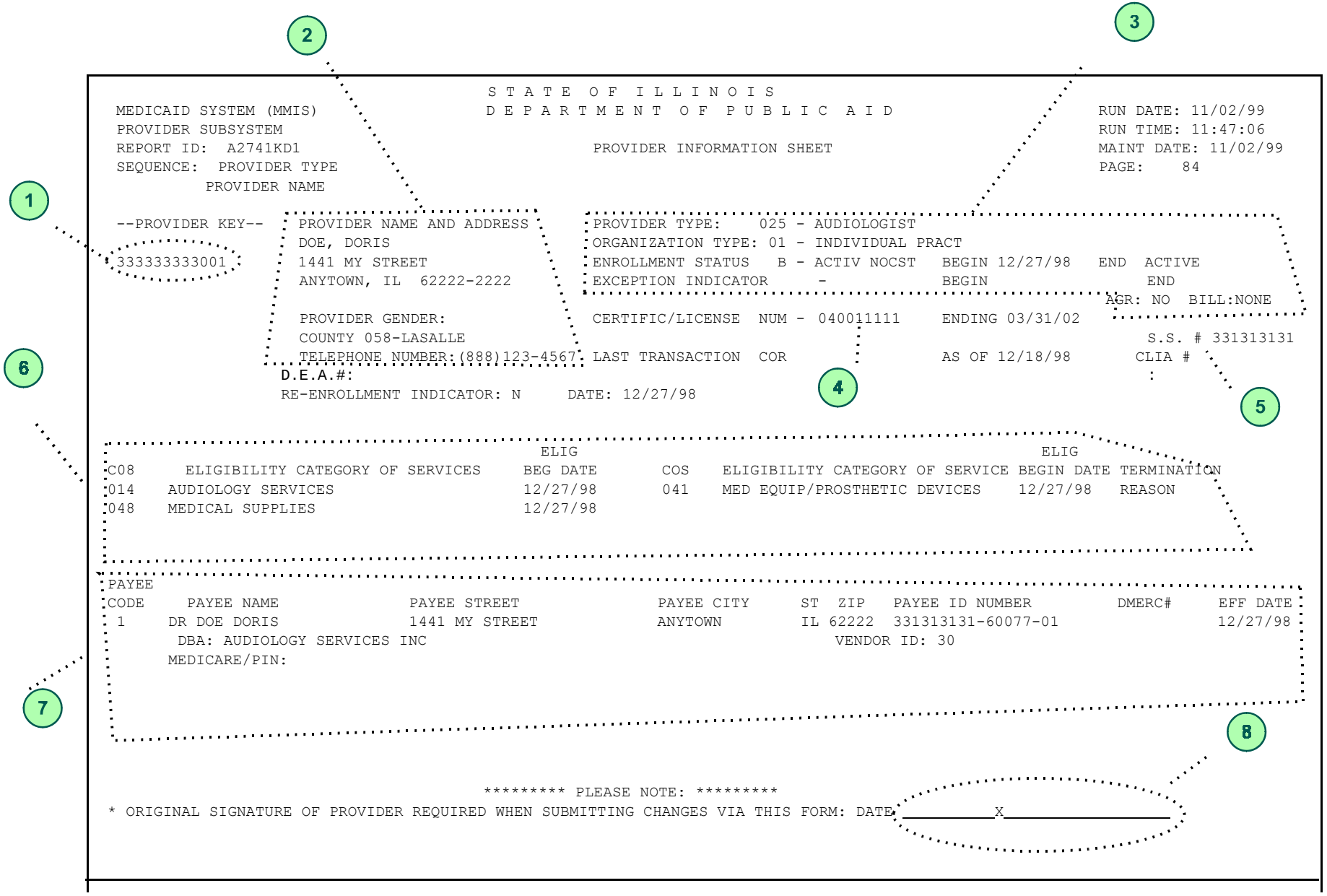
The **MEDICARE/PIN** or the **DMERC #** is the number assigned to

the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 **SIGNATURE**

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX E-5a
Reduced Facsimile of Provider Information Sheet



S T A T E O F I L L I N O I S
D E P A R T M E N T O F P U B L I C A I D

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

PROVIDER INFORMATION SHEET

RUN DATE: 11/02/99
RUN TIME: 11:47:06
MAINT DATE: 11/02/99
PAGE: 84

--PROVIDER KEY--
333333333001

PROVIDER NAME AND ADDRESS
DOE, DORIS
1441 MY STREET
ANYTOWN, IL 62222-2222

PROVIDER GENDER:
COUNTY 058-LASALLE
TELEPHONE NUMBER:(888)123-4567
D.E.A.#:
RE-ENROLLMENT INDICATOR: N DATE: 12/27/98

PROVIDER TYPE: 025 - AUDIOLOGIST
ORGANIZATION TYPE: 01 - INDIVIDUAL PRACT
ENROLLMENT STATUS B - ACTIV NOCST BEGIN 12/27/98 END ACTIVE
EXCEPTION INDICATOR - BEGIN END
AGR: NO BILL:NONE
CERTIFIC/LICENSE NUM - 040011111 ENDING 03/31/02
S.S. # 331313131
LAST TRANSACTION COR AS OF 12/18/98 CLIA # :

C08	ELIGIBILITY CATEGORY OF SERVICES	ELIG BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEGIN DATE	TERMINATION REASON
014	AUDIOLOGY SERVICES	12/27/98	041	MED EQUIP/PROSTHETIC DEVICES	12/27/98	
048	MEDICAL SUPPLIES	12/27/98				

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	DR DOE DORIS	1441 MY STREET	ANYTOWN	IL	62222	331313131-60077-01		12/27/98
	DBA: AUDIOLOGY SERVICES INC					VENDOR ID: 30		
	MEDICARE/PIN:							

********* PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____X_____

1
2
3
4
5
6
7
8